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Clark County Regional Support Network Policy Statement

Policy No.: CM31
Policy Title: Denial and Appeal of Denial – Adult Service Elements
Effective Date: September 1, 2001

Policy: All services provided by contracted agencies for Clark County Medicaid covered beneficiaries must be authorized for reimbursement, data monitoring and outcomes as needed by the PHIP and Washington State Mental Health Division. The provider agency designated or assigned clinician must make their own determination regarding medical necessity and the need to treat the client if clinically indicated based on their clinical assessment. The provider then requests authorization for payment from the RSN. The RSN based on the required IS documentation and clinical discussion with the provider, will approve, deny or modify with the provider the services to be authorized for payment.

Denial of service authorization, whether in part or in whole, shall be based upon but not limited to the following: client ineligibility for Medicaid funded services, incomplete data requirements, lack of documented medical necessity, treatment outside of best practice standards and non-compliance with authorization timelines. An appeal and grievance process is available when disagreements occur about service authorization decisions.

Reference: Clark County RSN contract, WAC 388-865-0255 and any other applicable RCWs and WAC statutes or code.

Procedure:

1. The provider agency designee or assigned clinician will make their own clinical determination regarding medical necessity and the need to treat the client based on their clinical judgment. Services provided without RSN authorization will not be credited towards the agency's performance objectives.
2. Provider agencies must have an internal Denial of Service Policy and Procedure as part of their Complaint and Grievance procedures. The RSN will be familiar with all contracted provider agencies Denial of Service policies and procedures. Provider agencies submit reports reflecting consumer complaints on a monthly basis to the RSN. (See Complaint and Grievance Policy and Procedure.)
3. A request for service authorization is transmitted to RSN via the IS system. The request is reviewed by RSN staff to determine appropriateness of request with regards to level of service and level of functioning. Any questions or concerns regarding the authorization request will be discussed with agency staff.

4. If RSN staff determines that the service level is inappropriate, a discussion will occur with the agency staff either negotiating or denying the authorization.
5. A denial of an authorization will be based on the following: Insufficient information available, medical necessity is not present, or less restrictive alternatives are available.
6. The RSN will not deny the authorization for services to a Medicaid enrollee without offering an opportunity for further peer consultation and, if necessary, review by other RSN staff.
7. All inpatient psychiatric hospitalization payment denials will be reviewed with the RSN medical consultant prior to denial of payment being given.
8. A review may be conducted via telephone and the following options will be offered:
 - a) Further discussion with the authorizing Clinical Care Manager utilizing any additional clinical documentation.
 - b) Peer review with a Clinical Care Manager not involved in the original review.
 - c) If disagreement continues, an informal phone review with the RSN Director in consultation with the RSN Medical Consultant
 - d) For inpatient payment denials, an expedited telephone review with the RSN medical consultant may be offered.
9. In event of continued disagreement regarding the authorization denial, and the original decision is upheld following the RSN Medic Consultant review, a formal Denial of Authorization letter will be sent to the referring source with a copy to the consumer.
10. The letter will state the following information:
 - a) The specific reason for the denial of authorization.
 - b) The effective date of denial.
 - c) The appeal process available to the consumer and the referring or treating professional.
 - d) The recipients will have 60 days from the receipt of the letter to appeal a denial of authorization for service.
11. *If there is continued disagreement on the provider agency's behalf regarding a care management decision, the provider may utilize the following appeal process. The provider must request a written appeal of the decision within 60 days of receipt of the formal denial letter. The appeal must contain clinical rationale addressing the RSN's reasons for any medical records that have bearing on the rationale for the continued treatment must also be submitted. The PHIP will have the RSN Medical Consultant review the request for appeal, along with additional documentation submitted by the provider. If the RSN Medical consultant was involved in the original denial, a medical consultant not previously involved with the case will be assigned to review the appeal.*
12. The consumer may also request an appeal of a denial decision. The RSN Ombudsman, as well as the provider agency staff, is available to assist the consumer in filing an appeal. The Clark County Ombudsman's phone number is (360)833-1846 or toll free at (866) 666-5070.

13. The consumer may file a grievance according to the Clark County RSN Consumer Complaint and Grievance Policy.

Approved By: _____


CD

Michael Piper, Director

Clark County

Department of Community Services

Date: _____

11-21-05